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Before the Committee on Insurance & Real Estate
Hartford, Connecticut
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Testifying in opposition to:

HB 5410: An Act Concerning High Deductible Health Plans

SB 415: An Act Concerning Step Therapy, Adverse Determination, and Utilization Reviews

My name is Wyatt Bosworth and I am assistant counsel for CBIA, the Connecticut Business & Industry Association. CBIA is Connecticut's largest business organization, with thousands of member companies, small and large, representing a diverse range of industries from across the state. Ninety-five percent of our member companies are small businesses, with less than 100 employees.

HB 5410: An Act Concerning High Deductible Health Plans—OPPOSE

CBIA has concerns about Section 2 of HB 5410. Under this section, starting January 1, 2023, no group health insurance policy that is a high deductible health plan (HDHP) shall impose an annual deductible in an amount greater than the federal minimum as outlined in Section 220 or 223 of the IRS Code. Practically speaking, this would mean that state-regulated HDHPs would not be permitted to impose a deductible greater than $1,400 for an individual or $2,800 for a family.[1]

It should be noted first that this bill will have a narrow scope on HDHPs across the state. Self-funded plans (i.e. those of which the employer maintains capital reserve from which the medical claims are paid) are regulated by the federal government under ERISA. Section 2 applies strictly to fully-insured HDHPs which represent a smaller segment of the market primarily utilized by small and mid-size companies. The proposal to cap deductibles in this market will inevitably lead to plan designs which will include a combination of (1) premium

[1] High Deductible Health Plan (HDHP), HealthCare.gov (2022) https://www.healthcare.gov/glossary/high-deductible-health-plan/#:~:text=For%202021%2C%20the%20IRS%20defines,or%20%2414%2C000%20for%20a%20family.

increases; (2) out-of-pocket maximum increases; and/or (3) droppage of the HDHP plan and shifting to a plan that does not meet the requirements of a qualified HDHP but has various cost-sharing features like a high deductible limited to in-patient and out-patient services in order to reduce premiums.

According to a recent report published by the Kaiser Family Foundation[2], the vast majority of small firms which offer HDHPs have annual deductibles for individuals greater than $1,400:

SMALL FIRM INDIVIDUAL DEDUCTIBLE	$1,000-$1,999	$2,000-$2,999	$3,000 or More
HDHP/HRA	21%	27%	52%
HSA-Qualified HDHP	12%	44%	44%
HDHP/SO[3]	14%	39%	48%

That same report also shows that the vast majority of small firms offering HDHPs have annual deductibles for families greater than $2,800:

SMALL FIRM FAMILY DEDUCTIBLE	$2,000-$2,999	$3,000-$3,999	$4,000-$4,999	$5,000-$5,999	$6,000 or More
HDHP/HRA	18%	9%	13%	19%	41%
HSA-Qualified HDHP	3%	13%	26%	22%	36%
HDHP/SO	8%	11%	21%	22%	38%

[2] 2021 Employer Health Benefits Survey, Kaiser Family Foundation (Nov. 10, 2021) https://www.kff.org/report-section/ehbs-2021-section-8-high-deductible-health-plans-with-savings-option/

[3] *Id*. HDHP with a savings option defined by KFF as (1) health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with an HRA; or (2) HDHPs that meet the federal legal requirements to permit an enrollee to establish and contribute to an HSA,

If HB 5410 becomes law, the data are clear: the vast majority of small businesses offering qualified HDHPs will have to either redesign their plans or drop HDHP coverage altogether. Under the first scenario, premiums will have to increase dramatically to make up for the shorter time frame for which cost-sharing kicks in. Further, the out-of-pocket maximum for these plans will likely increase to require more cost-sharing before the insurance plan pays for everything in full.[4]

Under the second scenario, an employer may drop the HDHP altogether, opting instead for a non HSA-compatible insurance plan. Since only those who are enrolled in a qualified HDHP may contribute to an HSA, this would end the ability for either the employer or employee to contribute to the account; limiting the tax benefits that both employers and employees possess. For example, an employee's HSA is "triple tax advantaged," meaning that (1) HSA contributions are 100% tax deductible up to the annual maximum limit; (2) HSA funds can be used tax-free for any qualified medical expense; and (3) HSA funds grow tax-free with no restrictions or "use it to lose it" limitations.

For employers, HSAs include a number of tax benefits: (1) HSA contributions are tax-deductible as a business expense; and (2) contributions are exempt from FICA taxes. An employer can maximize HSA benefits by setting up a cafeteria plan and lowering payroll tax liability and exempting employers from IRS comparability rules.

In summary, HB 5410 will result in more expensive health insurance for the vast majority of small businesses that currently offer qualified HDHPs. If deductibles are capped at the federal minimum, premiums will have to increase, out-of-pocket limits will increase, cost-sharing will increase, and for many businesses, HDHPs and the tax advantages of HSA's will be too expensive to offer. CBIA strongly urges the committee to oppose this bill. Thank you.

SB 415: An Act Concerning Step Therapy, Adverse Determination and Utilization Reviews—OPPOSE

CBIA is concerned about the potential cost increase for small and large group employer-sponsored health plans if SB 415 is passed into law. Step therapy is an effective tool that health plans, pharmacy benefit managers, and

[4] The federal limit on out-of-pocket maximums is $7,050 for self-only HDHP coverage and $14,100 for family HDHP coverage.

employers utilize to ensure that all clinically sound and cost-effective treatment options are tried before more expensive medicines are prescribed.

Research studies show that step therapy and prior authorization have demonstrated savings of more than 10% in targeted categories of drugs.[5] The loss of savings from prior authorization and step therapy would increase projected drug expenditures by an estimated 6.75% over the next ten years.[6] Connecticut small businesses simply cannot afford any further increases to their health insurance costs. Last summer, the Connecticut Insurance Department approved premium increases in the small group market by an average of 6.7%.

SB 415 has a much wider scope regarding step therapy than the two bills heard in the Public Health Committee earlier this week. Under Section 1, step therapy would be prohibited for prescribed drugs to treat "a behavioral health condition or chronic, disabling or life-threatening condition or disease for an insured who has been diagnosed with such a condition or disease." This broad prohibition will remove step therapy and its cost and quality safeguards from a multitude of prescription drugs.

This proposed prohibition on step therapy is unnecessary given the extensive regulation that currently exists to ensure consumer protection. For example, step therapy for any prescription drug is limited to only 60 days of use.[7] After the 60-day period, the provider can deem the therapy drug regimen "clinically ineffective" and the insurance company must then authorize the dispensation and coverage for the new drug requested by the provider.[8] The provider can even circumvent the 60-day step therapy window by following an expeditious override provision laid out in state statute. For example, a provider that can demonstrate that the drug regimen required has been ineffective in past treatment, is expected to be ineffective, will cause or will likely

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[5] *Increased Costs Associated With Proposed State Legislation Impacting PBM Tools,* PCMA (April 2020). https://www.pcmanet.org/wp-content/uploads/2020/04/Visante-Study-on-the-Increased-Costs-Associated-With-State-Legislation-Impacting-PBM-Tools-April-2020.pdf.

[6] *Id.*

[7] Conn. Gen. Stat. 38a-510(a)(2) ("No insurance company . . . may . . . require . . . the use of step therapy for (A) any prescribed drug for longer than sixty days . . . .").

[8] Conn. Gen. Stat. 38a(a)(3) ("At the expiration of the time period . . . an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective . . . at which time the insurance company . . . shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider . . . .).

cause an adverse reaction or physical harm, or is not in the best interest of the insured, can have the process waived under medical necessity.[9]

In addition to the above step therapy protections, state statute also establishes a process for urgent care requests and expedited reviews. For example, insurance carriers are required by law to respond to an urgent care request within 72 hours of receiving the request.[10] This process ensures that step therapy does not unduly delay covered persons with severe pain, life-threatening conditions, substance use disorders, and mental health disorders from receiving treatment.

In summary, SB 415 will lead to increased health insurance costs for employers. Step therapy is an important tool that employers, health plans, and PBMs utilize to ensure patients receive clinically appropriate and cost effective drug therapies. Given the rigorous step therapy protections currently offered under state statute and Insurance Department regulation, we believe this proposal is not warranted. CBIA urges the committee to oppose SB 415. Thank you.

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[9] Conn. Gen. Stat. 38(b)(1) ("Any override process . . . shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regiment required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevan physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity.").

[10] Conn. Gen. Stat. 38a-591(a)(38) ("'Urgent care request' means a request for a health care service or course of treatment (A) for which the time period for making a non-urgent care request determination (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (ii) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested, or (B) for a substance use disorder, as described in section 17a-458, or for a co-occurring mental disorder, or (C) for a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, as defined in section 38a-496, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.").